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CHAPTER 72.

LONG TERM CARE INSURANCE ACT

SECTION 38-72-10. Purpose

The purpose of this chapter is to promote the public interest, to promote the availability of long term care insurance policies, to protect applicants for long term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long term care insurance, to facilitate public understanding and comparison of long term care insurance policies, and to facilitate flexibility and innovation in the development of long term care insurance coverage.

SECTION 38-72-20. Chapter not to supersede other insurance laws; exceptions; applications.

This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies must not be applied to long term care insurance.

SECTION 38-72-30. Short title.

This chapter may be known and cited as the “Long Term Care Insurance Act”.

SECTION 38-72-40. Definitions.

Unless the context requires otherwise, as used in this chapter:

(1)(a) “Long term care insurance” means an insurance policy or a rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long term care insurance. It also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term also includes qualified long term care contracts. Long term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or a similar organization to the extent they otherwise are authorized to issue life or health insurance. Long term care insurance does not include an insurance policy offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(b) With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care. Notwithstanding another provision of this chapter, a product advertised, marketed, or offered as long term care insurance is subject to the provisions of this chapter.

(2) “Applicant” means:

(a) in the case of an individual long term care insurance policy the person who seeks to contract for benefits; and

(b) in the case of a group long term care insurance policy, the proposed certificate holder.

(3) "Certificate" means any certificate issued under a group long term care insurance policy, which policy has been delivered or issued for delivery in this State.

(4) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the insurance department.

(5) "Group long term care insurance" means a long term care insurance policy which is delivered or issued for delivery in this State and issued to:

(a) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof of the labor organizations; or

(b) any professional, trade, or occupational association for its members or former or retired members or combination thereof if such association:

(i) is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance; or

(c) an association or to a trust or to the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the department that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the purposes of its members, except for credit unions, the association collects dues or solicits contributions from members, and the members have voting privileges and representation on the governing board and committees. Ninety days after the filing, the association is considered to have satisfied the organizational requirements unless the director or his designee makes a finding that the association does not satisfy those organizational requirements.

(d) a group other than as described in items (5)(a), (5)(b), and (5)(c), subject to a finding by the director or his designee that the issuance of the group policy is not contrary to the best interest of the public, the issuance of the group policy would result in economies of acquisition or administration, and the benefits are reasonable in relation to the premiums charged.

(6) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, or any similar organization.

(7)(a) "Qualified long term care insurance contract" or "federally tax-qualified long term care insurance contract" means an individual or a group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(i) the only insurance protection provided under the contract is coverage of qualified long term care services. A contract does not fail to satisfy the requirements of this item by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(ii) the contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subsubitem do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act

only as a secondary payor. A contract does not fail to satisfy the requirements of this subsubitem by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which payments relate;

(iii) the contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(iv) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subsubitem (v);

(v) all refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund if death occurs of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(vi) the contract meets the consumer protection provisions provided in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(b) “Qualified long term care insurance contract” or “federally tax-qualified long term care insurance contract” also means the portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Section 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

SECTION 38-72-50. Group long term care insurance policy must meet requirements of chapter to be offered in state.

No group long term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in Section 38-72-40(5)(d) unless this State or another state having statutory and regulatory long term care insurance requirements substantially similar to those adopted in this State has made a determination that the requirements have been met.

SECTION 38-72-60. General assembly to approve regulations; terms and conditions applicable to long term care insurance policy and group policy; advertising restrictions.

(A) The director or his designee shall submit to the General Assembly for approval regulations to carry out the purposes of this chapter. These regulations may include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long term care insurance policies, terms of renewal, initial and subsequent conditions of eligibility, nonduplication of coverage provision, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

(B) A long term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated except for nonpayment of the premium;

(2) contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(C) The following applies to preexisting conditions:

(1) A long term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in Section 38-72-40(5)(a), may not use a definition of “preexisting condition” that is more restrictive than the following: “Preexisting condition” means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(1) A long term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in Section 38-72-40(5)(a), may not use a definition of “preexisting condition” that is more

restrictive than the following: “Preexisting condition” means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(2) A long term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in Section 38-72-40(5)(a), may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The director or his designee may extend the limitation periods provided in items (1) and (2) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of “preexisting condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in item (2) expires. A long term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period in item (2).

(D)(1) A long term care insurance policy may not be delivered or issued for delivery in this State if the policy conditions eligibility for benefits:

(a) on a prior hospitalization requirement;

(b) provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(2)(a) A long term care insurance policy containing post-confinement, post-acute care, or recuperative benefits clearly must label in a separate paragraph of the policy or certificate entitled “Limitations or Conditions on Eligibility for Benefits” limitations or conditions, including the required number of days of confinement.

(b) A long term care insurance policy or rider that conditions eligibility of post-confinement, post-acute care, or recuperative benefits on the prior receipt of institutional care may not require a prior institutional stay of more than thirty days.

(c) A long term care insurance policy or rider that provides benefits only following institutionalization may not condition these benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

(E) The director may adopt regulations establishing loss ratio standards for long term care insurance policies provided that a specific reference to long term care insurance policies is contained in the regulation.

(F) The following applies to the right of the policyholder to return the policy:

(1) Long term care insurance applicants have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached to it stating in substance that the applicant has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group as defined in Section 38-72-40(5)(a), the applicant is not satisfied for any reason.

(2) This subsection applies to denials of applications and any refund must be made within thirty days of the return or denial.

(G)(1) An outline of coverage must be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The director or his designee shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(b) For agent solicitations, an agent shall deliver the outline of coverage before the presentation of an application or enrollment form.

(c) For direct response solicitations, the outline of coverage must be presented in conjunction with an application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 38-72-40(5)(a), an outline of coverage is not required to be delivered, provided that the information described in this subsection is contained in other materials relating to enrollment. Upon request, these other materials must be made available to the director.

(2) The outline of coverage must include a:

(a) description of the principal benefits and coverage provided in the policy;

(b) statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including a reservation in the policy of a right to change the premium. Continuation or conversion provisions of group coverage must be described specifically;

(d) statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) description of the terms under which the policy or certificate may be returned and premium refunded;

(f) brief description of the relationship of cost of care and benefits;

(g) statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

(H) A certificate issued pursuant to a group long term care insurance policy delivered or issued for delivery in this State must include a:

(1) description of the principal benefits and coverage provided in the policy;

(2) statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) statement that the group master policy determines governing contractual provisions.

(I) If an application for a long term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.

(J) At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long term care benefits within the policy or by rider. For direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request but, regardless of a request, shall make the delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary also must include:

(1) an explanation of how the long term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;

(3) exclusions, reductions, and limitations on benefits of long term care;

(4) if applicable to the policy type:

(a) a disclosure of the effects of exercising other rights under the policy;

(b) a disclosure of guarantees related to long term care costs of insurance charges; and

(c) current and projected maximum lifetime benefits; and

(5) the provisions of the policy summary listed in this subsection may be incorporated into a basic illustration required to be delivered in accordance with regulation 69-40, Life Insurance Policy Illustration Regulation or into the life insurance summary which is required to be delivered in accordance with regulation 69-30, Solicitation of Life Insurance Regulation.

(K) When a long term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder. The report must include:

- (1) long term care benefits paid out during the month;
- (2) an explanation of changes in the policy, such as death benefits or cash values, due to long term care benefits being paid out;
- (3) the amount of long term care benefits existing or remaining.

(L) If a claim under a long term care insurance contract is denied, the issuer, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative of the issuer, shall:

- (1) provide a written explanation of the reasons for the denial; and
- (2) make available all information directly related to the denial.

(M) A policy or rider advertised, marketed, or offered as long term care or nursing home insurance must comply with the provisions of this chapter.

(N) All insurers issuing long term care insurance policies must offer, at time of application, an optional benefit which provides that when an insured meets the requirements under the policy that care in a nursing home or community residential care facility is necessary, the insured shall have the option of receiving necessary care in the home or community, with daily benefits at the same level that would have been paid for care in a nursing home or community residential care facility. This optional coverage may be provided by rider to the policy or included as part of the policy.

Notwithstanding the foregoing, insurers issuing long term care insurance policies may offer a home health care benefit which would provide benefits when care in the home only is necessary. This home health care benefit may provide lesser benefits than that provided by the policy for care in a nursing home or community residential care facility and may be provided either by rider to the policy or included as part of the policy.

SECTION 38-72-65. Recision of policy or denial of claim upon showing of misrepresentation; policy may be field issued; recovery of benefit payments; applicability to life policy provisions accelerating benefits for long term care.

(A) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is material to the acceptance of coverage.

(B) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(C) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; this policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(D)(1) A long term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, "field issued" means a policy or certificate issued by a producer or a third party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.

(E) If an insurer has paid benefits under the long term care insurance policy or certificate, the benefit payments may not be recovered by the insurer if the policy or certificate is rescinded.

(F) If the insured dies, this section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long term care. In this situation, the remaining death benefits under these policies are as provided by Section 38-63-220(d). In all other situations, this section applies to life insurance policies that accelerate benefits for long term care.

SECTION 38-72-67. Offer of a nonforfeiture benefit; group long term care policies; promulgation regulations.

(A) Except as provided in subsection (B), a long term care insurance policy may not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be available for a specified period of time following a substantial increase in premium rates.

(B) When a group long term care insurance policy is issued, the offer required in subsection (A) must be made to the group policyholder. However, if the policy is issued as group long term care insurance as defined in Section 39-72-40(5)(d) other than to a continuing care retirement community or other similar entity, the offering must be made to each proposed certificate holder.

(C) The director may promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (A).

SECTION 38-72-69. License requirements; training.

(A)(1) An individual may not sell, solicit, or negotiate long term care insurance unless the individual is licensed as an insurance producer for accident and health or life and has completed a one-time training course by July 1, 2009, and ongoing training every twenty-four months after that time. The training must meet the requirements provided in subsection (B).

(2) The training requirements of subsection (B) may be approved as continuing education courses under Section 38-43-106.

(B)(1) The one-time training required by this section must be no less than eight hours and the ongoing training required by this section must be no less than four hours.

(2) The training required under item (1) consists of topics related to long term care insurance, long term care services, and, if applicable, qualified state long term care insurance partnership programs including, but not limited to:

(a) state and federal regulations and requirements and the relationship between qualified state long term care insurance partnership programs and other public and private coverage of long term care services including Medicaid;

(b) available long term care services and providers;

(c) changes or improvements in long term care services or providers;

(d) alternatives to the purchase of private long term care insurance;

(e) the effect of inflation on benefits and the importance of inflation protection; and

(f) consumer suitability standards and guidelines.

(3) The training required by this section does not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(C)(1) An insurer subject to the provisions of this chapter shall obtain verification that a producer receives training required by subsection (A)(1) before a producer is permitted to sell, solicit, or negotiate the insurer's long term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request.

(2) An insurer subject to the provisions of this chapter shall maintain records with respect to the training of its partnership policies that allows the Department of Insurance to provide assurance to the state Medicaid agency that producers have received the training contained in subsection (B)(2)(a) as required by subsection (A)(1) and that producers have demonstrated an understanding of the partnership policies

and their relationship to public and private coverage of long term care, including Medicaid, in this State. These records must be maintained in accordance with the state's record retention requirements and must be made available to the director upon request.

(D) The satisfaction of these training requirements in any state are considered to satisfy the training requirements in this State.

SECTION 38-72-70. Regulations.

(A) The director may issue reasonable regulations to promote premium adequacy and to protect the policyholder if there is a substantial rate increase, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, penalties, and reporting practices for long term care.

(B) Regulations adopted pursuant to this chapter must be in accordance with the provisions of Chapter 23, Title 1.

SECTION 38-72-80. Severability; application of chapter.

(A) If a provision of this chapter or the application of it to a person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of the provisions to other persons or circumstances is not affected.

(B) The requirements of this chapter apply to policies delivered or issued for delivery in this State on or after its effective date.

SECTION 38-72-90. Penalties for violation of chapter.

Any insurer violating any provision of this chapter is subject to the penalties provided for in Sections 38-5-120 and 38-5-130 of the 1976 Code.

SECTION 38-72-100. Long term care premiums excluded in determining contribution to cost of Medicaid services.

Any premiums paid for long term care insurance must be excluded in determining the amount an individual must contribute towards the cost of any Medicaid services he receives.